



# Office of Health Facilities

## Application for Community Residential Facilities for the Elderly

Reference Guide for New Applicants

Let's begin!

# Log In to the platform

1 Enter your username and password.

2 Click the Log In button.

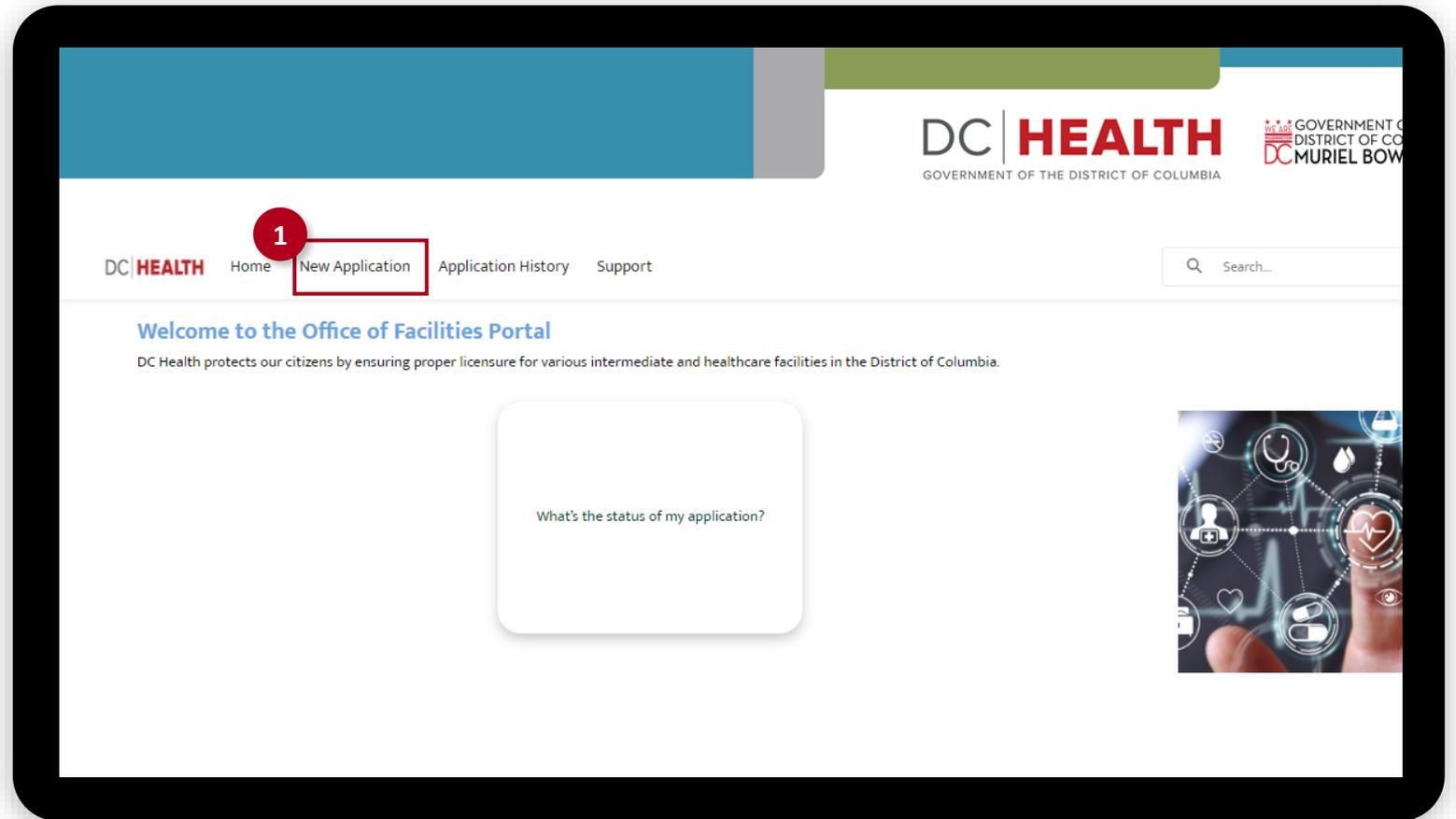


**TIP:** If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login page. At the top right, there is a header with the DC Health logo and the text "GOVERNMENT OF THE DISTRICT OF COLUMBIA" and "MURIEL BOWSER, MAYOR". The main content area features the DC Health logo, a "Welcome to the Office of Health Facilities Portal" message, and a "Login or Create an Account to:" section with a list of options: "Apply for a new medical facility license", "Renew an existing medical facility license", "Check the status of past applications", and "Seek support related to interactions with this office". Below this is an "About DC Health" section. The login form consists of a username field (containing "TestUser17"), a password field (containing "....."), and a "Log in" button. A red box highlights the username and password fields, with a "1" in a red circle next to it. Another red box highlights the "Log in" button, with a "2" in a red circle next to it. Below the login form are links for "Forgot your password?", "Forgot username?", and "Create New Account".

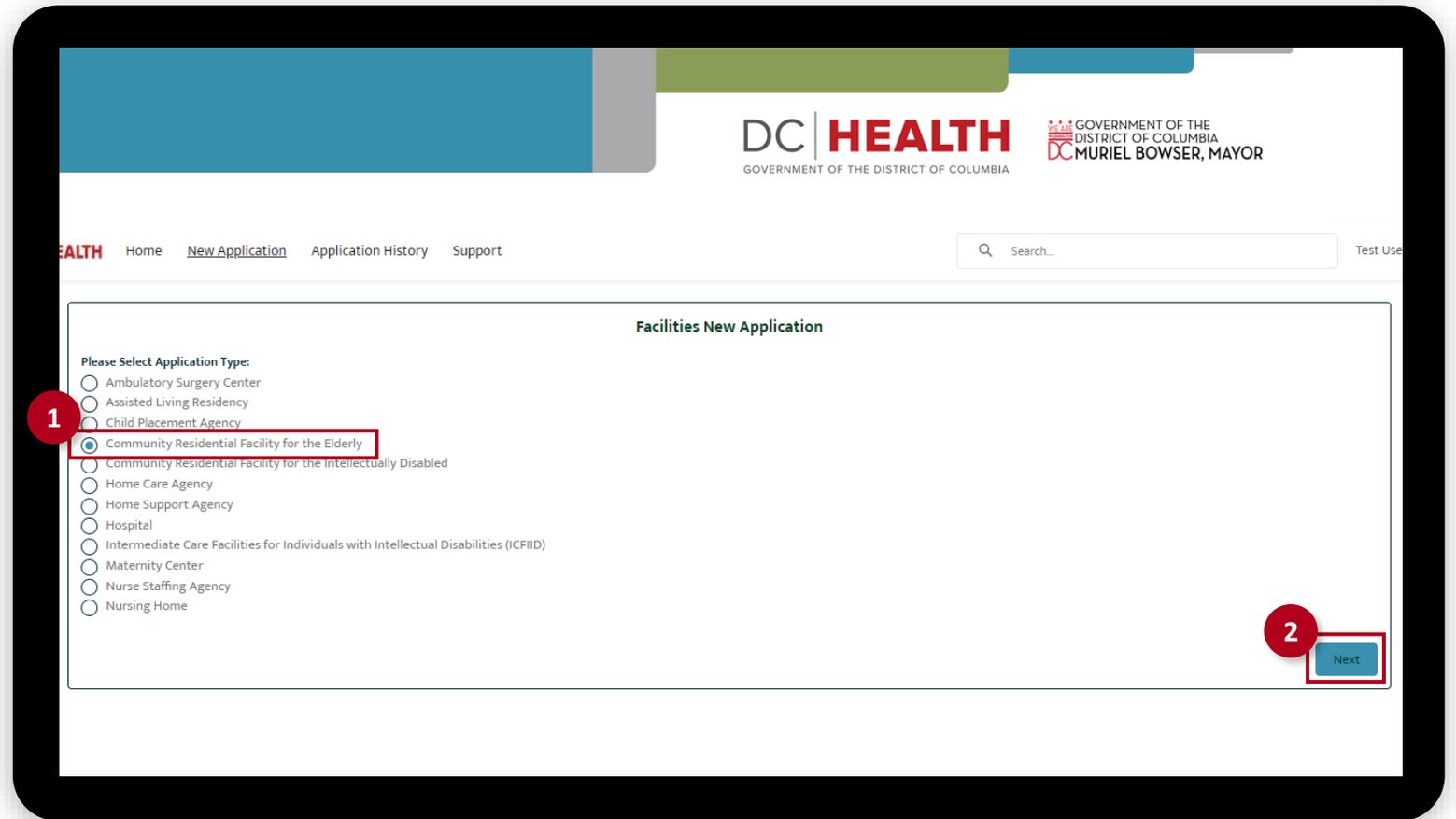
# Navigate to the New Application screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



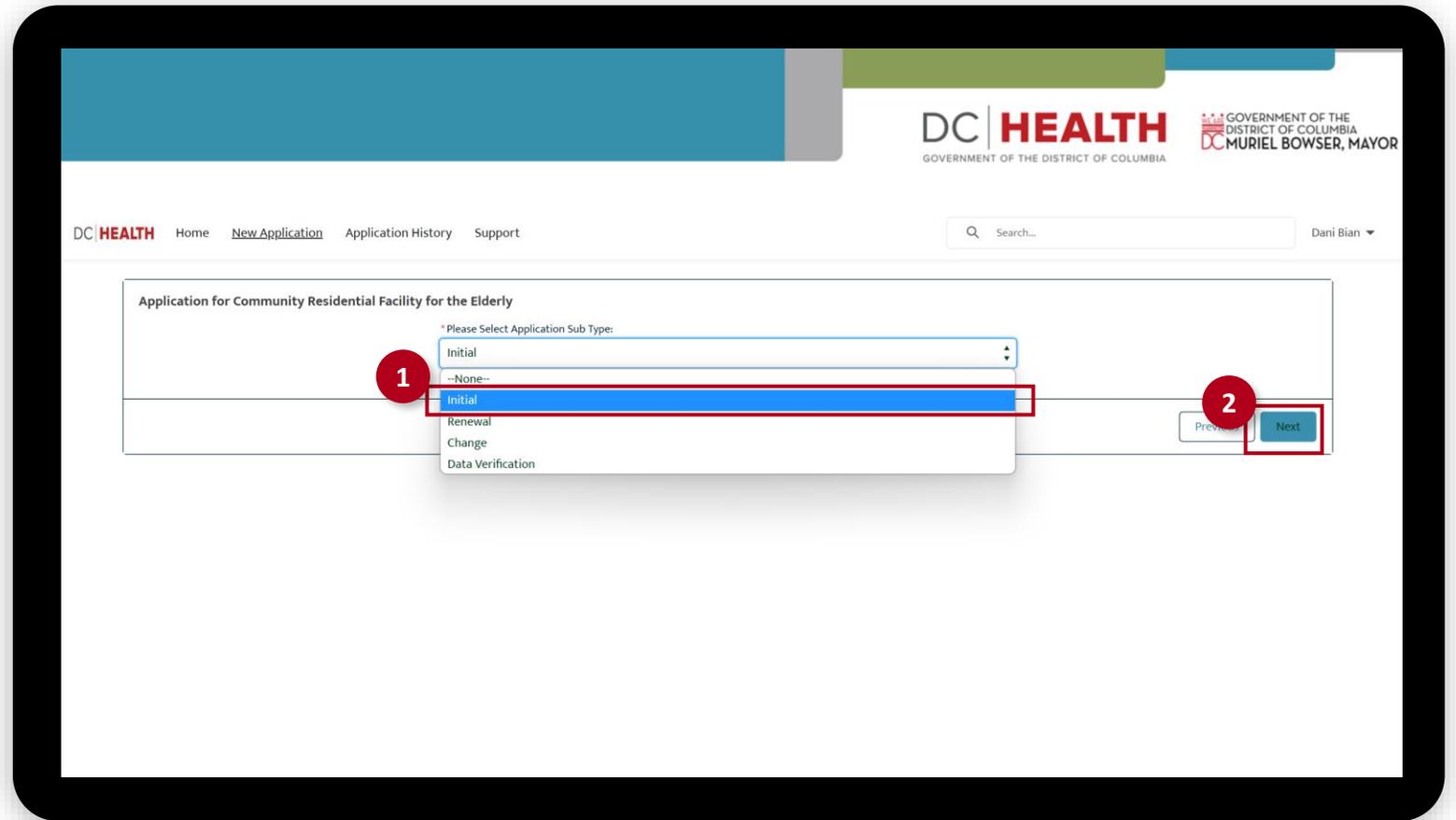
# Select the Facilities New Application

- 1 Select the **Community Residential Facility for the Elderly** option from the list.
- 2 Click the **Next** button.



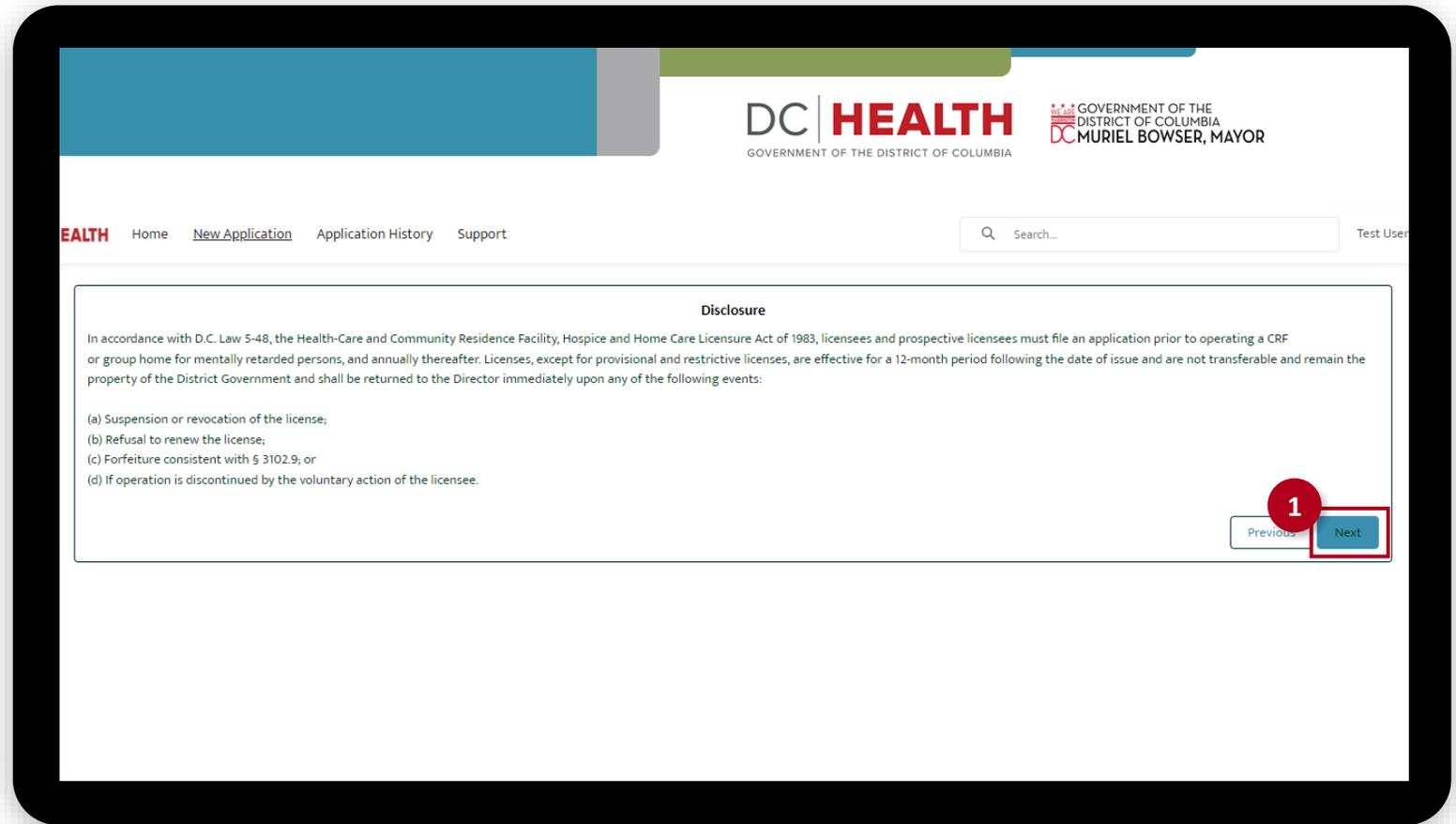
# Select the Application Sub Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Next** button.



# Accept Disclosure

- 1 After reading the full disclosure, click the **Next** button.



# Fill out the Facility Information

1 Fill out all the required fields.

2 Click the Save & Next button.

The screenshot shows a 'Facility Information' form with the following fields:

- \* Type of Facility: Level 1 (GHPID)
- \* Facility Name: Katelynn Kirlin
- \* City: North Felixfield
- \* Zip Code: 63608
- \* Fax Number: 83
- \* Street Address: 39927 Marjorie Lodge
- \* State: ID
- \* Telephone Number: 5084051437
- \* Email: your.email+fakedata59605@gmail.com
- \* Business After-Hours Number: 194-440-1067
- Website (if applicable): Quisquam assumenda facere delectus.
- \* Relationship of licensee to facility: Owner
- \* Number of Beds: 100
- \* Females: 90
- \* Males: 10
- \* Number of rotating Direct Support Staff: 51
- \* Do you provide 24 hour nursing care?: Yes

At the bottom right, there is a 'Save & Next' button.

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Licensee Information

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.

- 1 Fill out all the required fields.

The screenshot shows a 'Licensee Information' form with a red box highlighting the required fields. The form includes the following sections and fields:

- Business:**
  - \* First Name: Khalil
  - MI: Whitney Wolf
  - \* Last Name: VonRueden
  - \* City: Cierrafield
  - \* Address: 39543 Yvette Orchard
  - \* Zip Code: 20001
  - \* State: WI
- Business Owner Address:**
  - \* Address: 674 Wilton Shore
  - \* City: Jenkinsstad
  - \* State: OK
  - \* Zip Code: 20001
- \* Profit or Non-Profit?: Non-Profit
- \* Business Type: Sole Proprietorship
- \* Have you previously operated or been licensed to operate a group home/CRF in the District of Columbia?: Yes

If yes, was the license ever suspended or revoked?

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Licensee Information

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.

- 2 Click the **Upload Files** button if needed to attach relevant documents.
- 3 Click the **Save & Next** button.

The screenshot shows a web form with the following fields and callouts:

- State: OK
- Zip Code: 20001
- \* Profit or Non-Profit?: Non-Profit
- \* Business Type: Sole Proprietorship
- \* Have you previously operated or been licensed to operate a group home/CRF in the District of Columbia?: Yes
- If yes, was the license ever suspended or revoked?: Yes
- If yes, provide explanation: Dolorum laboriosam voluptas voluptatem explicabo harum similique.
- \* Is there any license application, Notice of Infraction or enforcement action pending as a result of your operation of a business in the District of Columbia?: No
- If yes, provide explanation: Ducimus quod sint possimus inventore.
- Callout 2: A red box highlights the "Upload Files" button and "Or drop files" text.
- Callout 3: A red box highlights the "Save & Next" button.

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Principals/Officers Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

The screenshot shows a web form titled "Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director)". The form is for "Principal/Officer of the Licensee - 1". It contains several input fields, some marked with an asterisk (\*) to indicate they are mandatory. The fields are: First Name (Brittany), Middle Name (Lavinia Hudson), Last Name (Dibbert), Street Address (29299 Alva Shore), City (Daniellastead), State (AK), Zip code (20001), Telephone Number (172-865-5359), Email (your.email+fakedata39187@gmail.com), and Title (Doctor). There is a checkbox labeled "Add more Principal/Officers?" and a "Save & Next" button. A red box highlights the "Save & Next" button, and a red circle with the number "2" is placed over it. Another red circle with the number "1" is placed over the "Principal/Officer of the Licensee - 1" header.



**TIP:** If you need to add multiple Principals/Officers, select the **Add more Principal/Officers?** box.

*The fields marked with \* are mandatory and must be filled out to continue.*

# Fill out the Facility Staffing Information

1 Fill out all the required fields.

2 Click the **Save & Next** button.

The screenshot shows a web form titled "Facility Staffing" with a red border. A red circle with the number "1" is in the top-left corner of the form area. A red circle with the number "2" is over the "Save & Next" button in the bottom-right corner. The form contains the following fields:

- Residence Director:**
  - \* Prefix: Mr. (dropdown)
  - \* Name: Samir Maggio
  - \* Title: Legacy Mobility Executive
  - \* Highest Level of Education Completed: Veum LLC
  - \* Name of Qualified Mental Retardation Professional (QMRP): Margarita O'Connell
- Other Professionals on Staff, if applicable:**
  - Director of Nursing:** Name: Tad Gusikowski
  - Primary Care Physician(s):** Name: Elouise Hoeger
  - Licensed Practical Nurse(s):** Name: Stanton Becker
  - Trained Medication Employee(s):** Name: Alexys Pfeffer
  - Live-In Staff:** Name: Jarvis Sipes

The fields marked with \* are mandatory and must be filled out to continue.

# Fill out the Insurance Coverage Information

- 1 Fill out all the required fields.
- 2 Click the **Upload Files** button if needed to attach relevant documents.
- 3 Click the **Save & Next** button.

**Insurance Coverage**

Attach documentary evidence of financial responsibility on the part of the applicant as stipulated below

**1** Hazard (Fire and extended coverage) Minimum of \$500 per resident or \$2000 per facility

* Agency Name Onie Bergnaum	* Street Address 5538 Heidenreich Island
* City Jaquanton	* State NH
* Zip Code 20001	* Hazard Amount of Coverage 500

Liability Insurance - Minimum of \$300,000 per occurrence

* Agency Name Faustino Pfeffer	* Street Address 18877 Herminia Hill
* City New Dallasfield	* State SC
* Zip Code 20001	* Liability Amount of Coverage 300,000

\* Professional Liability (Explain)  
Consequuntur culpa sunt repudiandae neque repellendus aspernatur.

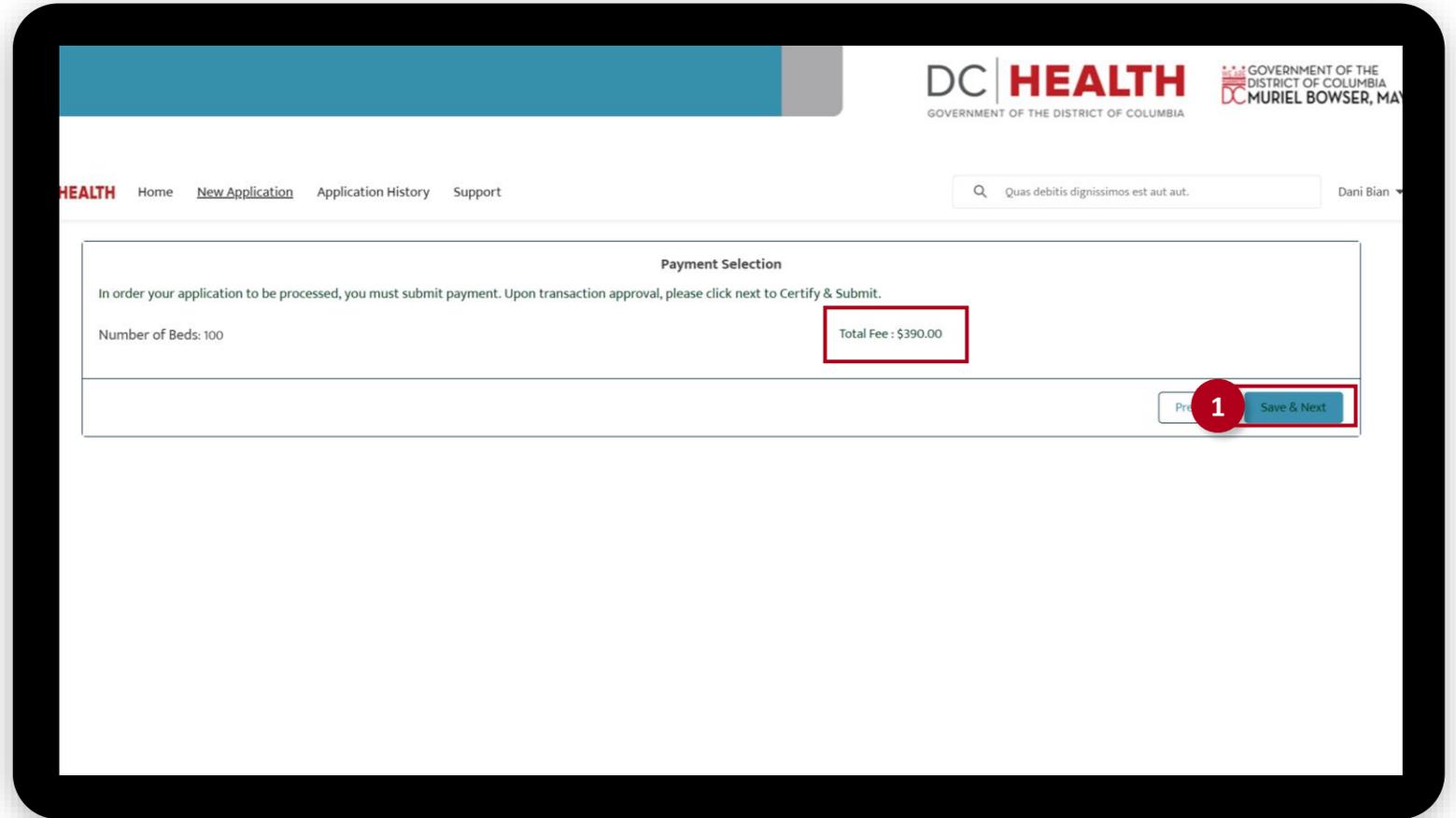
**2** Upload Files Or drop files

**3** Save & Next

The fields marked with \* are mandatory and must be filled out to continue.

# Payment Selection

- 1 Verify the **Total Fee** of the transaction and click the **Save & Next** button.



# Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

DC HEALTH Home [New Application](#) Application History Support

Sequi voluptas maiores nam. Test Users5

### Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

1

Billing Address	Payment Info
2879 Ortiz Crest	Solon Miller
788 Gottlieb Pass	3782 822463 10005
Fort Joan	09 / 25
Oregon	.... ?
16913-4451	

2 Pay \$390.00

Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

# Payment Wizard



- 3 Once the Transaction is approved, click the **Next** button.

DC HEALTH Home [New Application](#) Application History Support

Sequi voluptas maiores nam. Test Users5

### Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

Transaction approved

Pay \$390.00

Click the Next button at the bottom of this page to Certify & Submit the application.

3 Next

# Certify and Submit

1 Fill out the **Name** and **Date** fields.

2 Click the **Submit** button.



**TIP:** The date should correspond to the date you fill out and complete this form.

**HEALTH** Home [New Application](#) Application History Support

Soluta a animi magni quo aliquid voluptatem. Test User

### Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties\*. This information will be held confidential by the Department of Health.

\*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;

(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

\* Name  
Waylon Hyatt

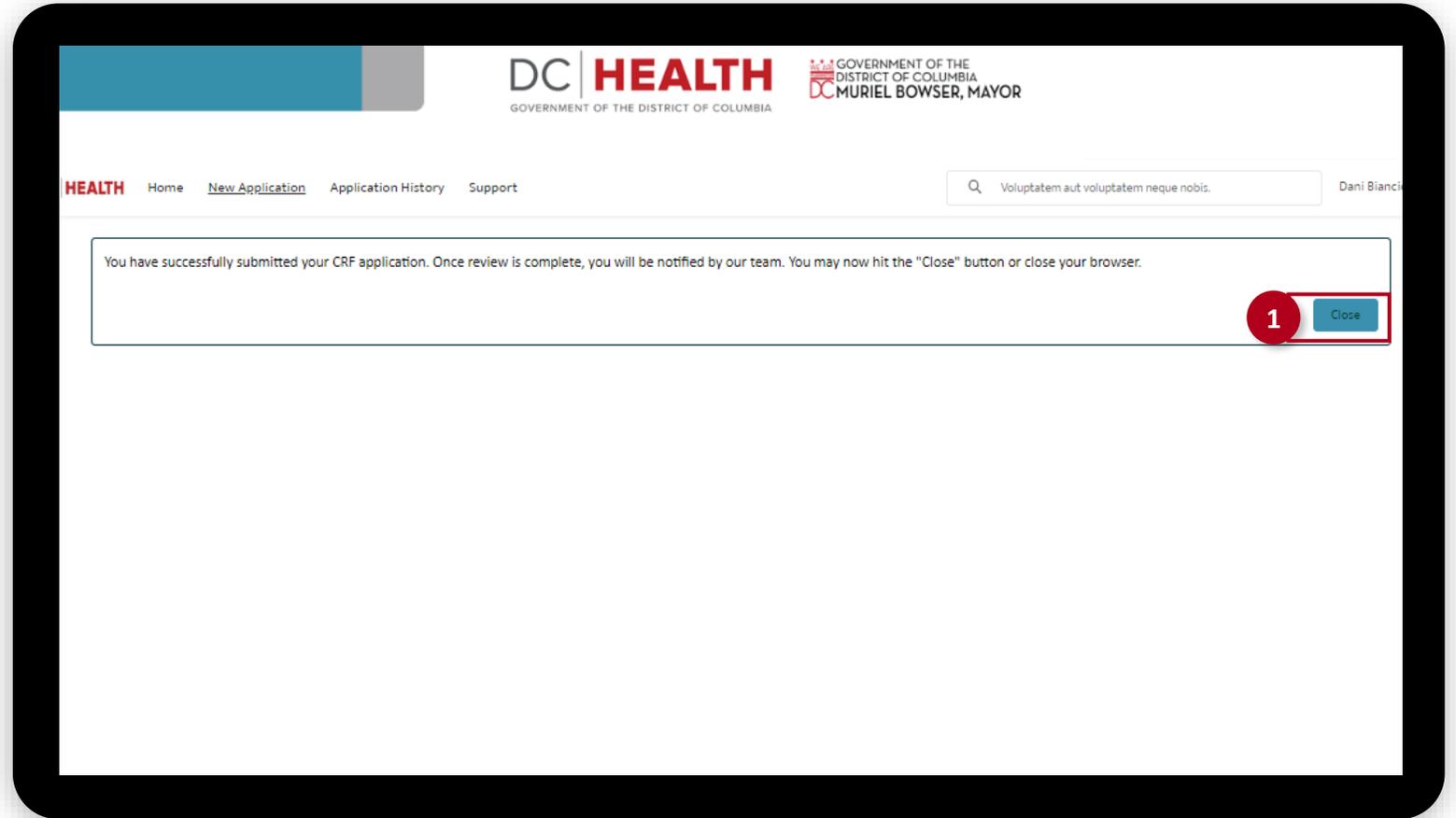
\* Date  
Oct 4, 2022

Submit

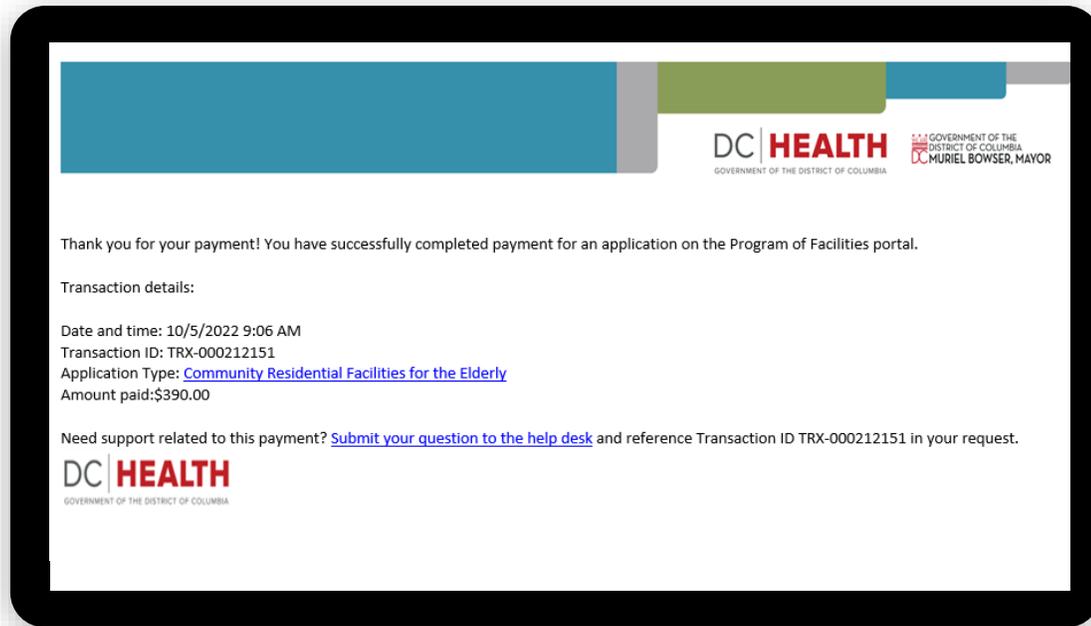
The fields marked with \* are mandatory and must be filled out to continue.

# Close the Application

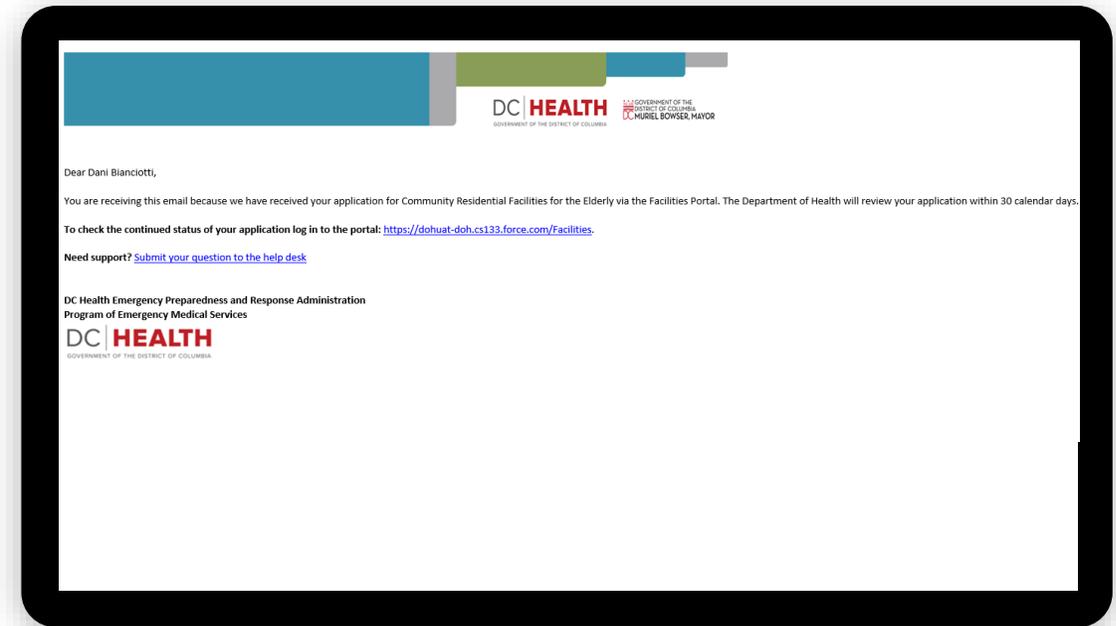
- 1 You have finished submitting your application. Click the **Close** button.



# E-mail confirmation



**1** Check if you have received confirmation of payment.



**2** Check if you have received confirmation for your application.

# Thank you!